DEPARTMENT OF HEALTH & FAMILY SERVICES
Division of Public Health
DPH 4702 (Rev. 08/03)

STATE OF WISCONSIN
Wis. Stats. 252.04

VACCINE ADMINISTRATION RECORD

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and the Social Security Number will be used by parent or guardian to access the Wisconsin Immunization Registry.

CHART NUMBER

Patient's Name (Last, First, Middle Initial)	Mother's Maiden Name (Last, First, Middle Initial)
Address	P. O. Box
City / County / State / Zip Code	
Email address (If applicable) / Home Telephone Number ( ) / Work Telephone Number ( ) / Extension	
Social Security Number / Date of Birth (mm/dd/yyyy) / Gender ☐ Male ☐ Female	
Race (Check one) ☐ African American ☐ Asian ☐ Caucasian ☐ Native American ☐ Other	Ethnicity (Check one) ☐ Hispanic ☐ Non-Hispanic

Eligibility Status (Check all that apply) This section must be completed. ☐ **Native American** ☐ **Medicaid Eligible** ☐ **Badger Care** ☐ **No Health Insurance** ☐ **Insured, Vaccines Covered** ☐ **Insured, Vaccines Not Covered**

Name of Physician	Name of Insurance Provider	Name of School or Day Care (If applicable)
Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)		Relationship to Patient
Okay to share immunization data with WIR? ☐ Yes ☐ No	Is reminder or recall contact allowed? ☐ Yes ☐ No	Would you like reminder/recall sent to you? ☐ Yes ☐ No

I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.

SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf.
X

Date Signed

FOR OFFICE USE

Vaccine	Route	Site Admin.*	Dose Number	Manufacturer	Lot Number	CDC Form Date
DTaP/DT	IM	RV LV RD LD	1 2 3 4 5			07/30/01
Hep B	IM	RV LV RD LD	1 2 3			07/11/01
Hib	IM	RV LV RD LD	1 2 3 4			12/16/98
Hib-Hep B Combined	IM	RV LV RD LD	1 2 3			Use dates from Hib and Hep B
MMR	SQ	RV LV RD LD	1 2			01/15/03
Polio	IM or SQ	RV LV RD LD	1 2 3 4			01/01/00
Td	IM	RV LV RD LD	1 2 3 4 5 6			6/10/94
Varicella	SQ	RV LV RD LD	1 2			12/16/98
Pneumococcal Conjugate (PCV7)	IM	RV LV RD LD	1 2 3 4			09/30/02
DTaP-Hep B-IPV Combined	IM	RV LV RD LD	1 2 3 4			Use dates from DTaP, Hep B, Polio
Influenza	IM	RV LV RD LD	1 2			Use most current Vaccine Info. Statement
Other		RV LV RD LD				

*RV=R Vastus Lateralis, LV=L Vastus Lateralis, RD=R Deltoid, LD=L Deltoid Subcutaneous injections are administered in the muscle "area".

SIGNATURE AND TITLE – Person Administering Vaccine
X

Date Vaccine Administered

Address – Clinic, Public Health Department